APPLICATION FOR ADMISSION

You may send the application by mail, fax, or email to the following information:
Address: 4901 Libbie Mill East Blvd, Ste 210
Richmond, VA 23230
Fax: 804-269-5003
Email: mstiltoner@gatewayhomes.org
For program questions please call Melissa Stiltoner at 804-712-4058

Date of Application:________________________ Date of Interview: _______

NAME:
(Last) (First) (Middle)

Current location or ADDRESS:____

CITY: ____________________________ STATE: __________ ZIP:_________________

PHONE NUMBER:_____________________SOCIAL SECURITY # __________________

GENDER (check): ❑ **Male** ❑ **Female**

MARITAL STATUS: ❑ **Single/Never Married** ❑ **Divorced**
❑ **Married** ❑ **Separated** ❑ **Widowed**

ETHNICITY (circle one):
❑ **African-American** ❑ **Caucasian (White)**
❑ **Asian** ❑ **Native American**
❑ **Hispanic** ❑ **Other**

AGE: ____________________ BIRTHDATE: ______________________

BIRTHPLACE: ___________________________________

Current Residency: County:____________________ City:____________________

State: ____________________

Please clearly note if person is in the state hospital and a contact name and address.

Are you currently in a State Hospital? ❑ **Yes** ❑ **No**

If yes, which one? ____

HOW DID YOU HEAR ABOUT GATEWAY HOMES?______________________________

Clinical Information

1. **Current Diagnosis:**____

____

____

2. **Current Medications:**____

____

____

3. **Do you believe that you have a mental illness now and need to take medications?**

❑ **Yes** ❑ **No**

4. **Psychiatric History:**

   A. Age of onset of illness/symptoms: _________________________

   B. Number of State or Community Psychiatric Hospitalizations: ___________

   C. Name and Date of Major Hospitalizations: _________________________

   ____

   ____

   ____

   D. Past outpatient treatment history:______________________________

   ____

5. **Please check all the symptoms that you have previously experienced:**

Auditory/visual hallucinations ___ Yes _____ No
Delusional thought processes ___ Yes _____ No
Depressed mood ___ Yes _____ No
Mania ___ Yes _____ No
Anxiety ___ Yes _____ No Obsessions/
Compulsions ___ Yes _____ No
Eating-disordered behaviors ___ Yes _____ No

6. Have you ever attempted suicide? ❑ Yes ❑ No

If so, when and by what means?___________________________________

____

7. Have you ever engaged in self-harm behaviors (e.g., self-cutting, burning, head banging, etc.)

❑ Yes ❑ No

8. Have you ever engaged in physical or verbal aggression towards others?

If so, please explain ____

____

9. List any history of substance use including the type of substance, amount and date last used:____

____

What programs or steps have you participated in to help maintain and support your sobriety?

____

10. List any current medical conditions and allergies (include ALL allergies) that you have :

____

____

____

11. List any operations or surgeries that your have had including dates:

____

____

____

12. Have you experienced: a. Seizures ❑ Yes ❑ No
b. Fainting spells ❑ Yes ❑ No
c. Head injury ❑ Yes ❑ No

Daily Living

1. What is your current living situation? (Please check one)
❑ State hospital ❑ With family
❑ Community/Private Hospital ❑ Homeless
❑ Group Home ❑ Other
❑ Independent in an apartment/house

2. How long have you been in your current living situation? (Please check one)
❑ less than 1 month ❑ 6 months B one year
❑ 1-6 months ❑ more than one year

3. How many different places have you lived during the past year? ___________

4a. Have you ever lived independently?
❑ Yes ❑ No

b. If Yes, what was the longest time you lived independently?
❑ less than 1 month ❑ 6 months B one year
❑ 1-6 months ❑ more than one year

5. Please describe difficulties that you had while living independently or what has prevented you from living independently. ____________________________

____

____

6. Please check all of the activities that you are able to complete independently and without assistance from others:
❑ personal hygiene ❑ meal preparation
❑ personal finance/budgeting ❑ housekeeping
❑ medication administration

Educational/Vocational/Social

1. What is the highest grade you completed? ______________________

2. Did you attend special education classes? ❑ Yes ❑ No

If Yes, what type? ____________________________________

3. Have you ever served in the Armed Forces? ❑ Yes ❑ No
If Yes, list branch and dates of services:___________________________

4. **List employment held and dates:** ______________________________

____

____

____

5. **What are your hobbies, interests, special talents?** ____________________

____

6. **Describe your strengths and perceived limitations:**____________________

____

____

Future Goals

1. **Why do you want to come to GW:** ______________________________

____

____

2. **What do you hope for yourself for the future?** ____________________

____

3. **Please use this space to let the clinical team know any other information about you that you would like to share:**______________________________

____

____

____

Legal

1. Have you ever incurred legal charges? ❑ Yes ❑ No

If Yes, please describe and give dates charges incurred:_______________

____

____
____

2 . Have you ever physically assaulted someone? ❑ Yes ❑ No

If Yes, please describe any physical altercations you have had, including the date, what started it, and the result: ___________________________________
____

____

3. Have you ever engaged in destruction of property?
❑ Yes ❑ No

If Yes, please describe the incident(s), including the date and the result:

____

____

4. Have you ever been accused of, charged with, or convicted of a sexual offense?
❑ Yes ❑ No

5. Are you subject to a lifetime sex offender registration requirement in any state? ❑ Yes ❑ No

6. Do you have an advanced directive? ❑ Yes ❑ No

7. Do you have a legal status of Not Guilty by Reason of Insanity? ❑ Yes ❑ No

If so, what is your current level of privilege? _____________________________

Who is your hospital liaison? ____________________________________

8. Are you on Probation or Parole? ❑ Yes ❑ No
If so, how long are you under supervision? _______________

Who is your direct contact for Probation or Parole?
Name: _________________________________ Phone: ________________

Contact Information

1. DESIGNATED CONTACT NAME : ______________________________

CONTACT ADDRESS: ____

CITY: __________________________ STATE: ___________ ZIP: ______________

CONTACT PHONE NUMBER: __________________

2. NEXT OF KIN - NAME: ____

CONTACT ADDRESS: ____

CITY: __________________________ STATE: ___________ ZIP: ______________

CONTACT PHONE NUMBER: __________________

3. CASE MANAGER or Hospital Liaison:

NAME: ____

CONTACT ADDRESS: ____

CITY: _________________________ STATE: ___________ ZIP: _______________

CONTACT PHONE NUMBER: __________________ Email: ___________________

FINANCIAL INFORMATION

Medicaid Number: ____

Medicare Number: ____

Sources of Income:

1. Monthly amount of income: _______________________________________
2. What kind of income? (SSI, SSDI, SSA): ____________________________

   Employment: ____________ Military / Veterans Benefits: ________________

   Food Stamps: _________________ Any Other Income: ___________

3. Who is the payee of benefits?

   Name: _________________________________ Phone: ___________________

4. Who is your Gaurdian or Conservator?

Name: ______________________________ Phone: ____________________

5. Checking Account: ______________________ Savings Account: _______________

Do you have any:

❑ Certificate of Deposit ❑ Money Market Accounts
❑ Treasury Bills ❑ Stocks, bonds ❑ Retirement or pension
❑ Annuities ❑ Personal Property held as an investment ❑ Other

Have you received any lump sum payments during this past year, such as inheritances, insurance settlements, etc.? ____**YES** ____**NO**

Have you disposed of any assets for less than fair market value in the last two years? ____**YES** **NO**

Are you the beneficiary of a Trust Fund? ____**YES** ____**NO** If so, how much income do you receive from this trust yearly? ________________

Who controls the account? Name: ______________________ Phone: _________________________

If an applicant is approved for admission, we will need the following before admission:

1. Letter from the Social Security Administration determining the applicant's disability OR statement from Social Security Administration stating current benefit(s).
2. Copy of all insurance cards.
3. Copy of Social Security Card, Birth Certificate, and Picture ID.
4. Copy of Bank Statements.
5. Financial agreement or DAP arrangements made.
6. Physical and PPD test 30 days prior to admission.
7. Current Medical/Psych records.

I certify that the information provided for this application is complete and accurate.

Signature of Applicant: ____ Date: _______________